

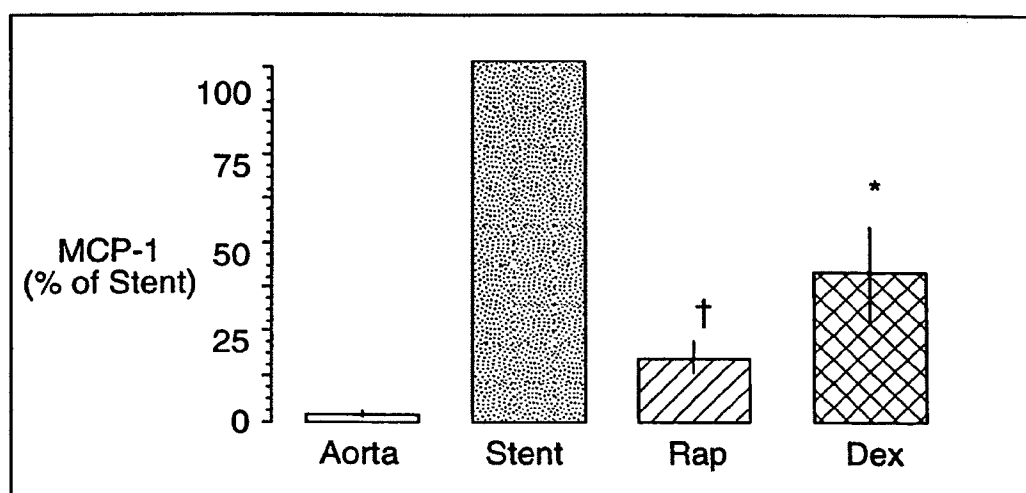
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**FIG. 1**



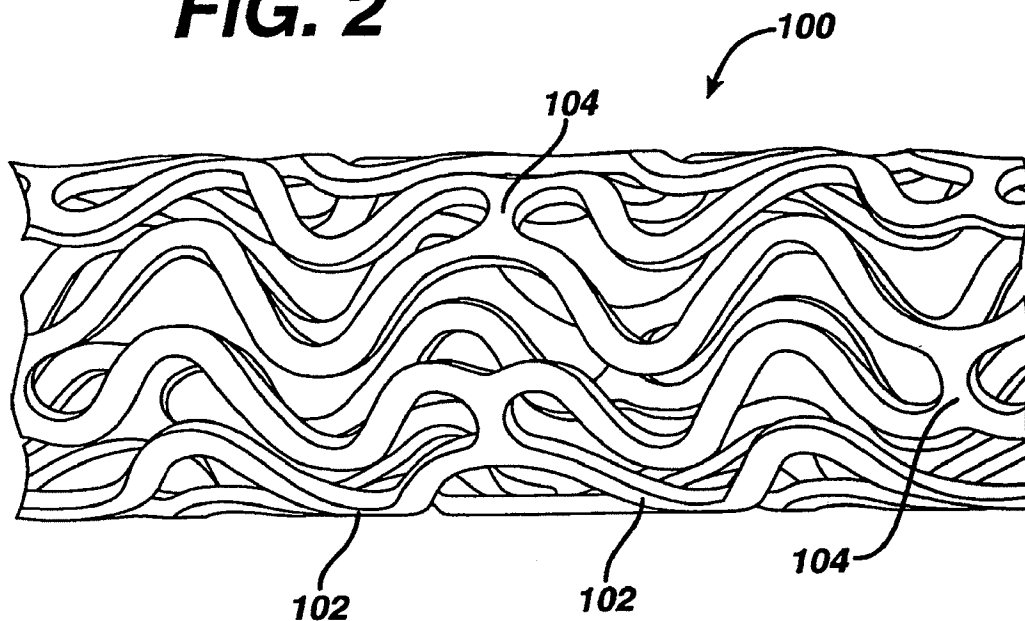
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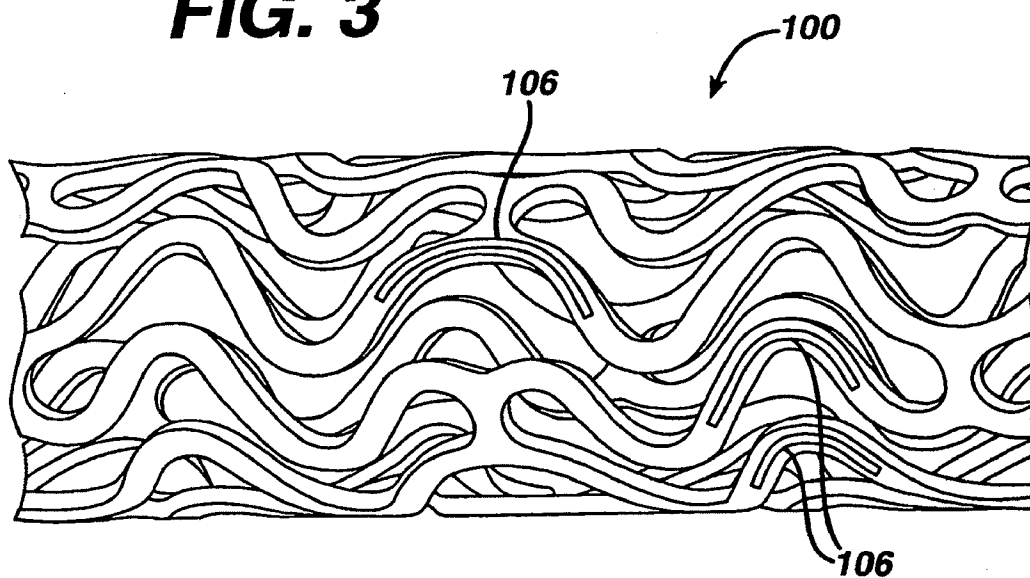
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**FIG. 2**



**FIG. 3**



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# **DRUG/DRUG DELIVERY SYSTEMS FOR THE PREVENTION AND TREATMENT OF VASCULAR DISEASE**

## **CROSS REFERENCE TO RELATED APPLICATIONS**

This application is a continuation-in-part of U.S. application Ser. No. 09/850,293, filed May 7, 2001, now abandoned, which in turn claims priority of U.S. Provisional Application No. 60/263,979, filed Jan. 25, 2001, U.S. Provisional Application No. 60/263,806, filed January 24, 2001, U.S. Provisional Application No. 60/262,614, filed Jan. 18, 2001, U.S. Provisional Application No. 60/262,461, filed Jan. 18, 2001, and is a continuation-in-part of U.S. Application No. 09/575,480, filed May 19, 2000, now pending, which in turn claims priority of U.S. Provisional Application No. 60/204,417, filed May 12, 2000.

## **BACKGROUND OF THE INVENTION**

### **1. Field of the Invention**

The present invention relates to drugs and drug delivery systems for the prevention and treatment of vascular disease, and more particularly to drugs and drug delivery systems for the prevention and treatment of neointimal hyperplasia.

### **2. Discussion of the Related Art**

Many individuals suffer from circulatory disease caused by a progressive blockage of the blood vessels that perfuse the heart and other major organs with nutrients. More severe blockage of blood vessels in such individuals often leads to hypertension, ischemic injury, stroke, or myocardial infarction. Atherosclerotic lesions, which limit or obstruct coronary blood flow, are the major cause of ischemic heart disease. Percutaneous transluminal coronary angioplasty is a medical procedure whose purpose is to increase blood flow through an artery. Percutaneous transluminal coronary angioplasty is the predominant treatment for coronary vessel stenosis. The increasing use of this procedure is attributable to its relatively high success rate and its minimal invasiveness compared with coronary bypass surgery. A limitation associated with percutaneous transluminal coronary angioplasty is the abrupt closure of the vessel which may occur immediately after the procedure and restenosis which occurs gradually following the procedure. Additionally, restenosis is a chronic problem in patients who have undergone saphenous vein bypass grafting. The mechanism of acute occlusion appears to involve several factors and may result from vascular recoil with resultant closure of the artery and/or deposition of blood platelets and fibrin along the damaged length of the newly opened blood vessel.

Restenosis after percutaneous transluminal coronary angioplasty is a more gradual process initiated by vascular injury. Multiple processes, including thrombosis, inflammation, growth factor and cytokine release, cell proliferation, cell migration and extracellular matrix synthesis each contribute to the restenotic process.

While the exact mechanism of restenosis is not completely understood, the general aspects of the restenosis process have been identified. In the normal arterial wall, smooth muscle cells proliferate at a low rate, approximately less than 0.1 percent per day. Smooth muscle cells in the vessel walls exist in a contractile phenotype characterized by eighty to ninety percent of the cell cytoplasmic volume occupied with the contractile apparatus. Endoplasmic reticulum, Golgi, and free ribosomes are few and are located in the perinuclear region. Extracellular matrix surrounds the

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smooth muscle cells and is rich in heparin-like glycosaminoglycans which are believed to be responsible for maintaining smooth muscle cells in the contractile phenotypic state (Campbell and Campbell, 1985).

Upon pressure expansion of an intracoronary balloon catheter during angioplasty, smooth muscle cells within the vessel wall become injured, initiating a thrombotic and inflammatory response. Cell derived growth factors such as platelet derived growth factor, fibroblast growth factor, epidermal growth factor, thrombin, etc., released from platelets, invading macrophages and/or leukocytes, or directly from the smooth muscle cells provoke proliferative and migratory responses in medial smooth muscle cells. These cells undergo a change from the contractile phenotype to a synthetic phenotype characterized by only a few contractile filament bundles, extensive rough endoplasmic reticulum, Golgi and free ribosomes. Proliferation/migration usually begins within one to two days post-injury and peaks several days thereafter (Campbell and Campbell, 1987; Clowes and Schwartz, 1985).

Daughter cells migrate to the intimal layer of arterial smooth muscle and continue to proliferate and secrete significant amounts of extracellular matrix proteins. Proliferation, migration and extracellular matrix synthesis continue until the damaged endothelial layer is repaired at which time proliferation slows within the intima, usually within seven to fourteen days post-injury. The newly formed tissue is called neointima. The further vascular narrowing that occurs over the next three to six months is due primarily to negative or constrictive remodeling.

Simultaneous with local proliferation and migration, inflammatory cells invade the site of vascular injury. Within three to seven days post-injury, inflammatory cells have migrated to the deeper layers of the vessel wall. In animal models employing either balloon injury or stent implantation, inflammatory cells may persist at the site of vascular injury for at least thirty days (Tanaka et al., 1993; Edelman et al., 1998). Inflammatory cells therefore are present and may contribute to both the acute and chronic phases of restenosis.

Numerous agents have been examined for presumed anti-proliferative actions in restenosis and have shown some activity in experimental animal models. Some of the agents which have been shown to successfully reduce the extent of intimal hyperplasia in animal models include: heparin and heparin fragments (Clowes, A. W. and Karnovsky M., *Nature* 265: 25-26, 1977; Guyton, J. R. et al., *Circ. Res.*, 46: 625-634, 1980; Clowes, A. W. and Clowes, M. M., *Lab. Invest.* 52: 611-616, 1985; Clowes, A. W. and Clowes, M. M., *Circ. Res.* 58: 839-845, 1986; Majesky et al., *Circ. Res.* 61: 296-300, 1987; Snow et al., *Am. J. Pathol.* 137: 313-330, 1990; Okada, T. et al., *Neurosurgery* 25: 92-98, 1989), colchicine (Currier, J. W. et al., *Circ.* 80: 11-66, 1989), taxol (Sollot, S. J. et al., *J. Clin. Invest.* 95: 1869-1876, 1995), angiotensin converting enzyme (ACE) inhibitors (Powell, J. S. et al., *Science*, 245: 186-188, 1989), angiopeptin (Lundergan, C. F. et al. *Am. J. Cardiol.* 17(Suppl. B):132B-136B, 1991), cyclosporin A (Jonasson, L. et al., *Proc. Natl., Acad. Sci.*, 85: 2303, 1988), goat-anti-rabbit PDGF antibody (Ferns, G. A. A., et al., *Science* 253: 1129-1132, 1991), terbinafine (Nemecsek, G. M. et al., *J. Pharmacol. Exp. Thera.* 248: 1167-1174, 1989), trapidil (Liu, M. W. et al., *Circ.* 81: 1089-1093, 1990), tranilast (Fukuyama, J. et al., *Eur. J. Pharmacol.* 318: 327-332, 1996), interferon-gamma (Hansson, G. K. and Holm, J., *Circ.* 84: 1266-1272, 1991), rapamycin (Marx, S. O. et al., *Circ. Res.* 76: 412-417, 1995), corticosteroids (Colburn, M. D. et al., *J. Vasc. Surg.* 15:

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510-518, 1992), see also Berk, B. C. et al., *J. Am. Coll. Cardiol.* 17: 111B-117B, 1991), ionizing radiation (Weinberger, J. et al., *Int. J. Rad. Onc. Biol. Phys.* 36: 767-775, 1996), fusion toxins (Farb, A. et al., *Circ. Res.* 80: 542-550, 1997) antisense oligonucleotides (Simons, M. et al., *Nature* 359: 67-70, 1992) and gene vectors (Chang, M. W. et al., *J. Clin. Invest.* 96: 2260-2268, 1995). Anti-proliferative effects on smooth muscle cells in vitro have been demonstrated for many of these agents, including heparin and heparin conjugates, taxol, tranilast, colchicine, ACE inhibitors, fusion toxins, antisense oligonucleotides, rapamycin and ionizing radiation. Thus, agents with diverse mechanisms of smooth muscle cell inhibition may have therapeutic utility in reducing intimal hyperplasia.

However, in contrast to animal models, attempts in human angioplasty patients to prevent restenosis by systemic pharmacologic means have thus far been unsuccessful. Neither aspirin-dipyridamole, ticlopidine, anti-coagulant therapy (acute heparin, chronic warfarin, hirudin or hirulog), thromboxane receptor antagonism nor steroids have been effective in preventing restenosis, although platelet inhibitors have been effective in preventing acute reocclusion after angioplasty (Mak and Topol, 1997; Lang et al., 1991; Popma et al., 1991). The platelet GP IIb/IIIa receptor, antagonist, Reopro is still under study but has not shown promising results for the reduction in restenosis following angioplasty and stenting. Other agents, which have also been unsuccessful in the prevention of restenosis, include the calcium channel antagonists, prostacyclin mimetics, angiotensin converting enzyme inhibitors, serotonin receptor antagonists, and anti-proliferative agents. These agents must be given systemically, however, and attainment of a therapeutically effective dose may not be possible; anti-proliferative (or anti-restenosis) concentrations may exceed the known toxic concentrations of these agents so that levels sufficient to produce smooth muscle inhibition may not be reached (Mak and Topol, 1997; Lang et al., 1991; Popma et al., 1991).

Additional clinical trials in which the effectiveness for preventing restenosis utilizing dietary fish oil supplements or cholesterol lowering agents has been examined showing either conflicting or negative results so that no pharmacological agents are as yet clinically available to prevent post-angioplasty restenosis (Mak and Topol, 1997; Franklin and Faxon, 1993; Serruys, P. W. et al., 1993). Recent observations suggest that the antilipid/antioxidant agent, probucol may be useful in preventing restenosis but this work requires confirmation (Tardif et al., 1997; Yokoi, et al., 1997). Probucol is presently not approved for use in the United States and a thirty-day pretreatment period would preclude its use in emergency angioplasty. Additionally, the application of ionizing radiation has shown significant promise in reducing or preventing restenosis after angioplasty in patients with stents (Teirstein et al., 1997). Currently, however, the most effective treatments for restenosis are repeat angioplasty, atherectomy or coronary artery bypass grafting, because no therapeutic agents currently have Food and Drug Administration approval for use for the prevention of post-angioplasty restenosis.

Unlike systemic pharmacologic therapy, stents have proven effective in significantly reducing restenosis. Typically, stents are balloon-expandable slotted metal tubes (usually, but not limited to, stainless steel), which, when expanded within the lumen of an angioplastied coronary artery, provide structural support through rigid scaffolding to the arterial wall. This support is helpful in maintaining vessel lumen patency. In two randomized clinical trials,

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stents increased angiographic success after percutaneous transluminal coronary angioplasty, by increasing minimal lumen diameter and reducing, but not eliminating, the incidence of restenosis at six months (Serruys et al., 1994; Fischman et al., 1994).

Additionally, the heparin coating of stents appears to have the added benefit of producing a reduction in sub-acute thrombosis after stent implantation (Serruys et al., 1996). Thus, sustained mechanical expansion of a stenosed coronary artery with a stent has been shown to provide some measure of restenosis prevention, and the coating of stents with heparin has demonstrated both the feasibility and the clinical usefulness of delivering drugs locally, at the site of injured tissue.

Accordingly, there exists a need for effective drugs and drug delivery systems for the effective prevention and treatment of neointimal thickening that occurs after percutaneous transluminal coronary angioplasty and stent implantation.

#### SUMMARY OF THE INVENTION

The drugs and drug delivery systems of the present invention provide a means for overcoming the difficulties associated with the methods and devices currently in use as briefly described above.

In accordance with one aspect, the present invention is directed to a method for the prevention of constrictive remodeling. The method comprises the controlled delivery, by release from an intraluminal medical device, of a compound in therapeutic dosage amounts.

In accordance with another aspect, the present invention is directed to a drug delivery device. The drug delivery device comprises an intraluminal medical device and a therapeutic dosage of an agent releasably affixed to the intraluminal medical device for the treatment of constrictive vascular remodeling.

The drugs and drug delivery systems of the present invention utilize a stent or graft in combination with rapamycin or other drugs/agents/compounds to prevent and treat neointimal hyperplasia, i.e. restenosis, following percutaneous transluminal coronary angioplasty and stent implantation. It has been determined that rapamycin functions to inhibit smooth muscle cell proliferation through a number of mechanisms. It has also been determined that rapamycin eluting stent coatings produce superior effects in humans, when compared to animals, with respect to the magnitude and duration of the reduction in neointimal hyperplasia. Rapamycin administration from a local delivery platform also produces an anti-inflammatory effect in the vessel wall that is distinct from and complimentary to its smooth muscle cell anti-proliferative effect. In addition, it has also been demonstrated that rapamycin inhibits constrictive vascular remodeling in humans.

Other drugs, agents or compounds which mimic certain actions of rapamycin may also be utilized in combination with local delivery systems or platforms.

The local administration of drugs, agents or compounds to stented vessels have the additional therapeutic benefit of higher tissue concentration than that which would be achievable through the systemic administration of the same drugs, agents or compounds. Other benefits include reduced systemic toxicity, single treatment, and ease of administration. An additional benefit of a local delivery device and drug, agent or compound therapy may be to reduce the dose of the therapeutic drugs, agents or compounds and thus limit their toxicity, while still achieving a reduction in restenosis.

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## BRIEF DESCRIPTION OF THE DRAWINGS

The foregoing and other features and advantages of the invention will be apparent from the following, more particular description of preferred embodiments of the invention, as illustrated in the accompanying drawings.

FIG. 1 is a chart indicating the effectiveness of rapamycin as an anti-inflammatory relative to other anti-inflammatories.

FIG. 2 is a view along the length of a stent (ends not shown) prior to expansion showing the exterior surface of the stent and the characteristic banding pattern.

FIG. 3 is a perspective view of the stent of FIG. 1 having reservoirs in accordance with the present invention.

## DETAILED DESCRIPTION OF THE PREFERRED EMBODIMENTS

As stated above, the proliferation of vascular smooth muscle cells in response to mitogenic stimuli that are released during balloon angioplasty and stent implantation is the primary cause of neointimal hyperplasia. Excessive neointimal hyperplasia can often lead to impairment of blood flow, cardiac ischemia and the need for a repeat intervention in selected patients in high risk treatment groups. Yet repeat revascularization incurs risk of patient morbidity and mortality while adding significantly to the cost of health care. Given the widespread use of stents in interventional practice, there is a clear need for safe and effective inhibitors of neointimal hyperplasia.

Rapamycin is a macrocyclic triene antibiotic produced by streptomyces hygroscopicus as disclosed in U.S. Pat. No. 3,929,992. It has been found that rapamycin inhibits the proliferation of vascular smooth muscle cells in vivo. Accordingly, rapamycin may be utilized in treating intimal smooth muscle cell hyperplasia, restenosis and vascular occlusion in a mammal, particularly following either biologically or mechanically mediated vascular injury, or under conditions that would predispose a mammal to suffering such a vascular injury. Rapamycin functions to inhibit smooth muscle cell proliferation and does not interfere with the re-endothelialization of the vessel walls.

Rapamycin functions to inhibit smooth muscle cell proliferation through a number of mechanisms. In addition, rapamycin reduces the other effects caused by vascular injury, for example, inflammation. The operation and various functions of rapamycin are described in detail below. Rapamycin as used throughout this application shall include rapamycin, rapamycin analogs, derivatives and congeners that bind FKBP12 and possess the same pharmacologic properties as rapamycin.

Rapamycin reduces vascular hyperplasia by antagonizing smooth muscle proliferation in response to mitogenic signals that are released during angioplasty. Inhibition of growth factor and cytokine mediated smooth muscle proliferation at the late G1 phase of the cell cycle is believed to be the dominant mechanism of action of rapamycin. However, rapamycin is also known to prevent T-cell proliferation and differentiation when administered systemically. This is the basis for its immunosuppressive activity and its ability to prevent graft rejection.

The molecular events that are responsible for the actions of rapamycin, a known anti-proliferative, which acts to reduce the magnitude and duration of neointimal hyperplasia, are still being elucidated. It is known, however, that rapamycin enters cells and binds to a high-affinity cytosolic protein called FKBP12. The complex of rapamycin and

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FKBP12 in turn binds to and inhibits a phosphoinositide (PI)-3 kinase called the "mammalian Target of Rapamycin" or TOR. TOR is a protein kinase that plays a key role in mediating the downstream signaling events associated with mitogenic growth factors and cytokines in smooth muscle cells and T lymphocytes. These events include phosphorylation of p27, phosphorylation of p70 s6 kinase and phosphorylation of 4BP-1, an important regulator of protein translation.

It is recognized that rapamycin reduces restenosis by inhibiting neointimal hyperplasia. However, there is evidence that rapamycin may also inhibit the other major component of restenosis, namely, negative remodeling. Remodeling is a process whose mechanism is not clearly understood but which results in shrinkage of the external elastic lamina and reduction in luminal area over time, generally a period of approximately three to six months in humans.

Negative or constrictive vascular remodeling may be quantified angiographically as the percent diameter stenosis at the lesion site where there is no stent to obstruct the process. If late lumen loss is abolished in-lesion, it may be inferred that negative remodeling has been inhibited. Another method of determining the degree of remodeling involves measuring in-lesion external elastic lamina area using intravascular ultrasound (IVUS). Intravascular ultrasound is a technique that can image the external elastic lamina as well as the vascular lumen. Changes in the external elastic lamina proximal and distal to the stent from the post-procedural timepoint to four-month and twelve-month follow-ups are reflective of remodeling changes.

Evidence that rapamycin exerts an effect on remodeling comes from human implant studies with rapamycin coated stents showing a very low degree of restenosis in-lesion as well as in-stent. In-lesion parameters are usually measured approximately five millimeters on either side of the stent i.e. proximal and distal. Since the stent is not present to control remodeling in these zones which are still affected by balloon expansion, it may be inferred that rapamycin is preventing vascular remodeling.

The data in Table 1 below illustrate that in-lesion percent diameter stenosis remains low in the rapamycin treated groups, even at twelve months. Accordingly, these results support the hypothesis that rapamycin reduces remodeling.

TABLE 1.0

Angiographic In-Lesion Percent Diameter Stenosis (%, mean $\pm$ SD and "n=") In Patients Who Received a Rapamycin-Coated Stent			
Coating Group	Post Placement	4-6 month Follow Up	12 month Follow Up
Brazil	10.6 $\pm$ 5.7 (30)	13.6 $\pm$ 8.6 (30)	22.3 $\pm$ 7.2 (15)
Netherlands	14.7 $\pm$ 8.8	22.4 $\pm$ 6.4	—

Additional evidence supporting a reduction in negative remodeling with rapamycin comes from intravascular ultrasound data that was obtained from a first-in-man clinical program as illustrated in Table 2 below.

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TABLE 2.0

Matched IVUS data in Patients Who Received a Rapamycin-Coated Stent			
IVUS Parameter	Post (n=)	4-Month Follow-Up (n=)	12-Month Follow-Up (n=)
Mean proximal vessel area (mm <sup>2</sup> )	16.53 ± 3.53 (27)	16.31 ± 4.36 (28)	13.96 ± 2.26 (13)
Mean distal vessel area (mm <sup>2</sup> )	13.12 ± 3.68 (26)	13.53 ± 4.17 (26)	12.49 ± 3.25 (14)

The data illustrated that there is minimal loss of vessel area proximally or distally which indicates that inhibition of negative remodeling has occurred in vessels treated with rapamycin-coated stents.

Other than the stent itself, there have been no effective solutions to the problem of vascular remodeling. Accordingly, rapamycin may represent a biological approach to controlling the vascular remodeling phenomenon.

It may be hypothesized that rapamycin acts to reduce negative remodeling in several ways. By specifically blocking the proliferation of fibroblasts in the vascular wall in response to injury, rapamycin may reduce the formation of vascular scar tissue. Rapamycin may also affect the translation of key proteins involved in collagen formation or metabolism.

Rapamycin used in this context includes rapamycin and all analogs, derivatives and congeners that bind FKBP12 and possess the same pharmacologic properties as rapamycin.

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In a preferred embodiment, the rapamycin is delivered by a local delivery device to control negative remodeling of an arterial segment after balloon angioplasty as a means of reducing or preventing restenosis. While any delivery device may be utilized, it is preferred that the delivery device comprises a stent that includes a coating or sheath which elutes or releases rapamycin. The delivery system for such a device may comprise a local infusion catheter that delivers rapamycin at a rate controlled by the administrator.

Rapamycin may also be delivered systemically using an oral dosage form or a chronic injectible depot form or a patch to deliver rapamycin for a period ranging from about seven to forty-five days to achieve vascular tissue levels that are sufficient to inhibit negative remodeling. Such treatment is to be used to reduce or prevent restenosis when administered several days prior to elective angioplasty with or without a stent.

Data generated in porcine and rabbit models show that the release of rapamycin into the vascular wall from a nonerodible polymeric stent coating in a range of doses (35-430 ug/5-18 mm coronary stent) produces a peak fifty to fifty-five percent reduction in neointimal hyperplasia as set forth in Table 3 below. This reduction, which is maximal at about twenty-eight to thirty days, is typically not sustained in the range of ninety to one hundred eighty days in the porcine model as set forth in Table 4 below.

TABLE 3.0

Animal Studies with Rapamycin-coated stents. Values are mean ± Standard Error of Mean							
Study	Duration	Stent <sup>1</sup>	Neointimal Area		% Change From		
			Rapamycin	N (mm <sup>2</sup> )	Polyme	Metal	
Porcine							
98009	14 days	Metal		8	2.04 ± 0.17		
		1X + rapamycin	153 µg	8	1.66 ± 0.17*	-42%	-19%
		1X + TC300 + rapamycin	155 µg	8	1.51 ± 0.19*	-47%	-26%
99005	28 days	Metal		10	2.29 ± 0.21		
				9	3.91 ± 0.60**		
		1X + TC30 + rapamycin	130 µg	8	2.81 ± 0.34		+23%
99006	28 days	1X + TC100 + rapamycin	120 µg	9	2.62 ± 0.21		+14%
		Metal		12	4.57 ± 0.46		
		EVA/BMA 3X		12	5.02 ± 0.62		+10%
99011	28 days	1X + rapamycin	125 µg	11	2.84 ± 0.31* **	-43%	-38%
		3X + rapamycin	430 µg	12	3.06 ± 0.17* **	-39%	-33%
		3X + rapamycin	157 µg	12	2.77 ± 0.41* **	-45%	-39%
		Metal		11	3.09 ± 0.27		
99021	60 days			11	4.52 ± 0.37		
		1X + rapamycin	189 µg	14	3.05 ± 0.35		-1%
		3X + rapamycin/dex	182/363 µg	14	2.72 ± 0.71		-12%
99034	28 days	Metal		12	2.14 ± 0.25		
		1X + rapamycin	181 µg	12	2.95 ± 0.38		+38%
		Metal		8	5.24 ± 0.58		
20001	28 days	1X + rapamycin	186 µg	8	2.47 ± 0.33**		-53%
		3X + rapamycin/dex	185/369 µg	6	2.42 ± 0.64**		-54%
		Metal		6	1.81 ± 0.09		
20007	30 days	1X + rapamycin	172 µg	5	1.66 ± 0.44		-8%
		Metal		9	2.94 ± 0.43		
Rabbit							
99019	28 days	1XTC + rapamycin	155 µg	10	1.40 ± 0.11*		-52%*
99019	28 days	Metal		8	1.20 ± 0.07		

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TABLE 3.0-continued

Animal Studies with Rapamycin-coated stents. Values are mean $\pm$ Standard Error of Mean					
Study	Duration	Stent <sup>1</sup>	Rapamycin	Neointimal Area	% Change From
				N (mm <sup>2</sup> )	Polyme Metal
99020	28 days	EVA/BMA 1X		10 1.26 $\pm$ 0.16	+5%
		1X + rapamycin	64 $\mu$ g	9 0.92 $\pm$ 0.14	-27%
		1X + rapamycin	196 $\mu$ g	10 0.66 $\pm$ 0.12* **	-48%
		Metal		12 1.18 $\pm$ 0.10	-45%
		EVA/BMA 1X + rapamycin	197 $\mu$ g	8 0.81 $\pm$ 0.16	-32%

<sup>1</sup>Stent nomenclature: EVA/BMA 1X, 2X, and 3X signifies approx. 500  $\mu$ g, 1000  $\mu$ g, and 1500  $\mu$ g total mass (polymer + drug), respectively. TC, top coat of 30  $\mu$ g, 100  $\mu$ g, or 300  $\mu$ g drug-free BMA; Biphasic; 2  $\times$  1X layers of rapamycin in EVA/BMA separated by a 100  $\mu$ g drug-free BMA layer.

<sup>2</sup>0.25 mg/kg/d  $\times$  14 d preceded by a loading dose of 0.5 mg/kg/d  $\times$  3 d prior to stent implantation.

\*p < 0.05 from EVA/BMA control.

\*\*p < 0.05 from Metal;

<sup>3</sup>Inflammation score: (0 = essentially no intimal involvement; 1 = <25% intima involved; 2 =  $\geq$ 25% intima involved; 3 = >50% intima involved).

TABLE 4.0

180 day Porcine Study with Rapamycin-coated stents. Values are mean $\pm$ Standard Error of Mean								
Study	Duration	Stent <sup>1</sup>	Rapamycin	N	Neointimal Area	% Change From		Inflammation
					(mm <sup>2</sup> )	Polyme	Metal	Score #
20007 (ETP-2-002233-P)	3 days	Metal		10	0.38 $\pm$ 0.06			1.05 $\pm$ 0.06
		1XTC + rapamycin	155 $\mu$ g	10	0.29 $\pm$ 0.03		-24%	1.08 $\pm$ 0.04
	30 days	Metal		9	2.94 $\pm$ 0.43			0.11 $\pm$ 0.08
		1XTC + rapamycin	155 $\mu$ g	10	1.40 $\pm$ 0.11*		-52%*	0.25 $\pm$ 0.10
	90 days	Metal		10	3.45 $\pm$ 0.34			0.20 $\pm$ 0.08
		1XTC + rapamycin	155 $\mu$ g	10	3.03 $\pm$ 0.29		-12%	0.80 $\pm$ 0.23
	180 days	1X + rapamycin	171 $\mu$ g	10	2.86 $\pm$ 0.35		-17%	0.60 $\pm$ 0.23
		Metal		10	3.65 $\pm$ 0.39			0.65 $\pm$ 0.21
		1XTC + rapamycin	155 $\mu$ g	10	3.34 $\pm$ 0.31		-8%	1.50 $\pm$ 0.34
		1X + rapamycin	171 $\mu$ g	10	3.87 $\pm$ 0.28		+6%	1.68 $\pm$ 0.37

The release of rapamycin into the vascular wall of a human from a nonerodible polymeric stent coating provides superior results with respect to the magnitude and duration of the reduction in neointimal hyperplasia within the stent as compared to the vascular walls of animals as set forth above.

Humans implanted with a rapamycin coated stent comprising rapamycin in the same dose range as studied in animal models using the same polymeric matrix, as

described above, reveal a much more profound reduction in neointimal hyperplasia than observed in animal models, based on the magnitude and duration of reduction in neointima. The human clinical response to rapamycin reveals essentially total abolition of neointimal hyperplasia inside the stent using both angiographic and intravascular ultrasound measurements. These results are sustained for at least one year as set forth in Table 5 below.

TABLE 5.0

Patients Treated (N = 45 patients) with a Rapamycin-coated Stent		
Effectiveness Measures	Sirolimus FIM (N = 45 Patients, 45 Lesions)	95% Confidence Limit
Procedure Success (QCA)	100.0% (45/45)	[92.1%, 100.0%]
4-month In-Stent Diameter Stenosis (%)		
Mean $\pm$ SD (N)	4.8% $\pm$ 6.1% (30)	[2.6%, 7.0%]
Range (min, max)	(-8.2%, 14.9%)	
6-month In-Stent Diameter Stenosis (%)		
Mean $\pm$ SD (N)	8.9% $\pm$ 7.6% (13)	[4.8%, 13.0%]
Range (min, max)	(-2.9%, 20.4%)	
12-month In-Stent Diameter Stenosis (%)		
Mean $\pm$ SD (N)	8.9% $\pm$ 6.1% (15)	[5.8%, 12.0%]
Range (min, max)	(-3.0%, 22.0%)	

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TABLE 5.0-continued

Patients Treated (N = 45 patients) with a Rapamycin-coated Stent		
Effectiveness Measures	Sirolimus FIM (N = 45 Patients, 45 Lesions)	95% Confidence Limit
<u>4-month In-Stent Late Loss (mm)</u>		
Mean $\pm$ SD (N)	0.00 $\pm$ 0.29 (30)	[-0.10, 0.10]
Range (min, max)	(-0.51, 0.45)	
<u>6-month In-Stent Late Loss (mm)</u>		
Mean $\pm$ SD (N)	0.25 $\pm$ 0.27 (13)	[0.10, 0.39]
Range (min, max)	(-0.51, 0.91)	
<u>12-month In-Stent Late Loss (mm)</u>		
Mean $\pm$ SD (N)	0.11 $\pm$ 0.36 (15)	[-0.08, 0.29]
Range (min, max)	(-0.51, 0.82)	
<u>4-month Obstruction Volume (%) (IVUS)</u>		
Mean $\pm$ SD (N)	10.48% $\pm$ 2.78% (28)	[9.45%, 11.51%]
Range (min, max)	(4.60%, 16.35%)	
<u>6-month Obstruction Volume (%) (IVUS)</u>		
Mean $\pm$ SD (N)	7.22% $\pm$ 4.60% (13)	[4.72%, 9.72%],
Range (min, max)	(3.82%, 19.88%)	
<u>12-month Obstruction Volume (%) (IVUS)</u>		
Mean $\pm$ SD (N)	2.11% $\pm$ 5.28% (15)	[0.00%, 4.78%],
Range (min, max)	(0.00%, 19.89%)	
6-month Target Lesion Revascularization (TLR)	0.0% (0/30)	[0.0%, 9.5%]
12-month Target Lesion Revascularization (TLR)	0.0% (0/15)	[0.0%, 18.1%]

QCA = Quantitative Coronary Angiography  
SD = Standard Deviation  
IVUS = Intravascular Ultrasound

Rapamycin produces an unexpected benefit in humans when delivered from a stent by causing a profound reduction in in-stent neointimal hyperplasia that is sustained for at least one year. The magnitude and duration of this benefit in humans is not predicted from animal model data. Rapamycin used in this context includes rapamycin and all analogs, derivatives and congeners that bind FKBP12 and possess the same pharmacologic properties as rapamycin.

These results may be due to a number of factors. For example, the greater effectiveness of rapamycin in humans is due to greater sensitivity of its mechanism(s) of action toward the pathophysiology of human vascular lesions compared to the pathophysiology of animal models of angioplasty. In addition, the combination of the dose applied to the stent and the polymer coating that controls the release of the drug is important in the effectiveness of the drug.

As stated above, rapamycin reduces vascular hyperplasia by antagonizing smooth muscle proliferation in response to mitogenic signals that are released during angioplasty injury. Also, it is known that rapamycin prevents T-cell proliferation and differentiation when administered systemically. It has also been determined that rapamycin exerts a local inflammatory effect in the vessel wall when administered from a stent in low doses for a sustained period of time (approximately two to six weeks). The local anti-inflammatory benefit is profound and unexpected. In combination with the smooth muscle anti-proliferative effect, this dual mode of action of rapamycin may be responsible for its exceptional efficacy.

Accordingly, rapamycin delivered from a local device platform, reduces neointimal hyperplasia by a combination of anti-inflammatory and smooth muscle anti-proliferative effects. Rapamycin used in this context means rapamycin

and all analogs, derivatives and congeners that bind FKBP12 and possess the same pharmacologic properties as rapamycin. Local device platforms include stent coatings, stent sheaths, grafts and local drug infusion catheters or porous balloons or any other suitable means for the in situ or local delivery of drugs, agents or compounds.

The anti-inflammatory effect of rapamycin is evident in data from an experiment, illustrated in Table 6, in which rapamycin delivered from a stent was compared with dexamethasone delivered from a stent. Dexamethasone, a potent steroidal anti-inflammatory agent, was used as a reference standard. Although dexamethasone is able to reduce inflammation scores, rapamycin is far more effective than dexamethasone in reducing inflammation scores. In addition, rapamycin significantly reduces neointimal hyperplasia, unlike dexamethasone.

TABLE 6.0

Group	N=	Neointimal Area (mm <sup>2</sup> )	% Area Stenosis	Inflammation Score
Rapamycin				
Uncoated	8	5.24 $\pm$ 1.65	54 $\pm$ 19	0.97 $\pm$ 1.00
Dexamethasone	8	4.31 $\pm$ 3.02	45 $\pm$ 31	0.39 $\pm$ 0.24
(Dex)				
Rapamycin	7	2.47 $\pm$ 0.94*	26 $\pm$ 10*	0.13 $\pm$ 0.19*
(Rap)				
Rap + Dex	6	2.42 $\pm$ 1.58*	26 $\pm$ 18*	0.17 $\pm$ 0.30*

\* = significance level P < 0.05

Rapamycin has also been found to reduce cytokine levels in vascular tissue when delivered from a stent. The data in FIG. 1 illustrates that rapamycin is highly effective in reducing monocyte chemotactic protein (MCP-1) levels in

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the vascular wall. MCP-1 is an example of a proinflammatory/chemotactic cytokine that is elaborated during vessel injury. Reduction in MCP-1 illustrates the beneficial effect of rapamycin in reducing the expression of proinflammatory mediators and contributing to the anti-inflammatory effect of rapamycin delivered locally from a stent. It is recognized that vascular inflammation in response to injury is a major contributor to the development of neointimal hyperplasia.

Since rapamycin may be shown to inhibit local inflammatory events in the vessel it is believed that this could explain the unexpected superiority of rapamycin in inhibiting neointima.

As set forth above, rapamycin functions on a number of levels to produce such desired effects as the prevention of T-cell proliferation, the inhibition of negative remodeling, the reduction of inflammation, and the prevention of smooth muscle cell proliferation. While the exact mechanisms of these functions are not completely known, the mechanisms that have been identified may be expanded upon.

Studies with rapamycin suggest that the prevention of smooth muscle cell proliferation by blockade of the cell cycle is a valid strategy for reducing neointimal hyperplasia. Dramatic and sustained reductions in late lumen loss and neointimal plaque volume have been observed in patients receiving rapamycin delivered locally from a stent. The present invention expands upon the mechanism of rapamycin to include additional approaches to inhibit the cell cycle and reduce neointimal hyperplasia without producing toxicity.

The cell cycle is a tightly controlled biochemical cascade of events that regulate the process of cell replication. When cells are stimulated by appropriate growth factors, they move from G<sub>0</sub> (quiescence) to the G<sub>1</sub> phase of the cell cycle. Selective inhibition of the cell cycle in the G<sub>1</sub> phase, prior to DNA replication (S phase), may offer therapeutic advantages of cell preservation and viability while retaining anti-proliferative efficacy when compared to therapeutics that act later in the cell cycle i.e. at S, G<sub>2</sub> or M phase.

Accordingly, the prevention of intimal hyperplasia in blood vessels and other conduit vessels in the body may be achieved using cell cycle inhibitors that act selectively at the G<sub>1</sub> phase of the cell cycle. These inhibitors of the G<sub>1</sub> phase of the cell cycle may be small molecules, peptides, proteins, oligonucleotides or DNA sequences. More specifically, these drugs or agents include inhibitors of cyclin dependent kinases (cdk's) involved with the progression of the cell cycle through the G<sub>1</sub> phase, in particular cdk2 and cdk4.

Examples of drugs, agents or compounds that act selectively at the G<sub>1</sub> phase of the cell cycle include small molecules such as flavopiridol and its structural analogs that have been found to inhibit cell cycle in the late G<sub>1</sub> phase by antagonism of cyclin dependent kinases. Therapeutic agents that elevate an endogenous kinase inhibitory protein<sup>kip</sup> called P27, sometimes referred to as P27<sup>kip1</sup>, that selectively inhibits cyclin dependent kinases may be utilized. This includes small molecules, peptides and proteins that either block the degradation of P27 or enhance the cellular production of P27, including gene vectors that can transfect the gene to produce P27. Staurosporin and related small molecules that block the cell cycle by inhibiting protein kinases may be utilized. Protein kinase inhibitors, including the class of tyrphostins that selectively inhibit protein kinases to antagonize signal transduction in smooth muscle in response to a broad range of growth factors such as PDGF and FGF may also be utilized.

Any of the drugs, agents or compounds discussed above may be administered either systemically, for example,

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orally, intravenously, intramuscularly, subcutaneously, nasally or intradermally, or locally, for example, stent coating, stent covering or local delivery catheter. In addition, the drugs or agents discussed above may be formulated for fast-release or slow release with the objective of maintaining the drugs or agents in contact with target tissues for a period ranging from three days to eight weeks.

As set forth above, the complex of rapamycin and FKBP12 binds to and inhibits a phosphoinositide (PI)-3 kinase called the mammalian Target of Rapamycin or TOR. An antagonist of the catalytic activity of TOR, functioning as either an active site inhibitor or as an allosteric modulator, i.e. an indirect inhibitor that allosterically modulates, would mimic the actions of rapamycin but bypass the requirement for FKBP12. The potential advantages of a direct inhibitor of TOR include better tissue penetration and better physical/chemical stability. In addition, other potential advantages include greater selectivity and specificity of action due to the specificity of an antagonist for one of multiple isoforms of TOR that may exist in different tissues, and a potentially different spectrum of downstream effects leading to greater drug efficacy and/or safety.

The inhibitor may be a small organic molecule (approximate mw<1000), which is either a synthetic or naturally derived product. Wortmanin may be an agent which inhibits the function of this class of proteins. It may also be a peptide or an oligonucleotide sequence. The inhibitor may be administered either systemically (orally, intravenously, intramuscularly, subcutaneously, nasally, or intradermally) or locally (stent coating, stent covering, local drug delivery catheter). For example, the inhibitor may be released into the vascular wall of a human from a nonerodible polymeric stent coating. In addition, the inhibitor may be formulated for fast-release or slow release with the objective of maintaining the rapamycin or other drug, agent or compound in contact with target tissues for a period ranging from three days to eight weeks.

As stated previously, the implantation of a coronary stent in conjunction with balloon angioplasty is highly effective in treating acute vessel closure and may reduce the risk of restenosis. Intravascular ultrasound studies (Mintz et al., 1996) suggest that coronary stenting effectively prevents vessel constriction and that most of the late luminal loss after stent implantation is due to plaque growth, probably related to neointimal hyperplasia. The late luminal loss after coronary stenting is almost two times higher than that observed after conventional balloon angioplasty. Thus, inasmuch as stents prevent at least a portion of the restenosis process, the use of drugs, agents or compounds which prevent inflammation and proliferation, or prevent proliferation by multiple mechanisms, combined with a stent may provide the most efficacious treatment for post-angioplasty restenosis.

The local delivery of drugs, agents or compounds from a stent has the following advantages; namely, the prevention of vessel recoil and remodeling through the scaffolding action of the stent and the drugs, agents or compounds and the prevention of multiple components of neointimal hyperplasia. This local administration of drugs, agents or compounds to stented coronary arteries may also have additional therapeutic benefit. For example, higher tissue concentrations would be achievable than that which would occur with systemic administration, reduced systemic toxicity, and single treatment and ease of administration. An additional benefit of drug therapy may be to reduce the dose of the therapeutic compounds, thereby limiting their toxicity, while still achieving a reduction in restenosis.

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There are a multiplicity of different stents that may be utilized following percutaneous transluminal coronary angioplasty. Although any number of stents may be utilized in accordance with the present invention, for simplicity, one particular stent will be described in exemplary embodiments of the present invention. The skilled artisan will recognize that any number of stents may be utilized in connection with the present invention.

A stent is commonly used as a tubular structure left inside the lumen of a duct to relieve an obstruction. Commonly, stents are inserted into the lumen in a non-expanded form and are then expanded autonomously, or with the aid of a second device in situ. A typical method of expansion occurs through the use of a catheter-mounted angioplasty balloon which is inflated within the stenosed vessel or body passageway in order to shear and disrupt the obstructions associated with the wall components of the vessel and to obtain an enlarged lumen. As set forth below, self-expanding stents may also be utilized.

FIG. 2 illustrates an exemplary stent 100 which may be utilized in accordance with an exemplary embodiment of the present invention. The expandable cylindrical stent 100 comprises a fenestrated structure for placement in a blood vessel, duct or lumen to hold the vessel, duct or lumen open, more particularly for protecting a segment of artery from restenosis after angioplasty. The stent 100 may be expanded circumferentially and maintained in an expanded configuration, that is circumferentially or radially rigid. The stent 100 is axially flexible and when flexed at a band, the stent 100 avoids any externally-protruding component parts.

The stent 100 generally comprises first and second ends with an intermediate section therebetween. The stent 100 has a longitudinal axis and comprises a plurality of longitudinally disposed bands 102, wherein each band 102 defines a generally continuous wave along a line segment parallel to the longitudinal axis. A plurality of circumferentially arranged links 104 maintain the bands 102 in a substantially tubular structure. Essentially, each longitudinally disposed band 102 is connected at a plurality of periodic locations, by a short circumferentially arranged link 104 to an adjacent band 102. The wave associated with each of the bands 102 has approximately the same fundamental spatial frequency in the intermediate section, and the bands 102 are so disposed that the wave associated with them are generally aligned so as to be generally in phase with one another. As illustrated in the figure, each longitudinally arranged band 102 undulates through approximately two cycles before there is a link to an adjacent band.

The stent 100 may be fabricated utilizing any number of methods. For example, the stent 100 may be fabricated from a hollow or formed stainless steel tube that may be machined using lasers, electric discharge milling, chemical etching or other means. The stent 100 is inserted into the body and placed at the desired site in an unexpanded form. In one embodiment, expansion may be effected in a blood vessel by a balloon catheter, where the final diameter of the stent 100 is a function of the diameter of the balloon catheter used.

It should be appreciated that a stent 100 in accordance with the present invention may be embodied in a shape-memory material, including, for example, an appropriate alloy of nickel and titanium. In this embodiment, after the stent 100 has been formed it may be compressed so as to occupy a space sufficiently small as to permit its insertion in a blood vessel or other tissue by insertion means, wherein the insertion means include a suitable catheter, or flexible rod. On emerging from the catheter, the stent 100 may be configured to expand into the desired configuration where

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the expansion is automatic or triggered by a change in pressure, temperature or electrical stimulation.

FIG. 3 illustrates an exemplary embodiment of the present invention utilizing the stent 100 illustrated in FIG. 2. As illustrated, the stent 100 may be modified to comprise a reservoir 106. Each of the reservoirs may be opened or closed as desired. These reservoirs 106 may be specifically designed to hold the drug, agent, compound or combinations thereof to be delivered. Regardless of the design of the stent 100, it is preferable to have the drug, agent, compound or combinations thereof dosage applied with enough specificity and a sufficient concentration to provide an effective dosage in the lesion area. In this regard, the reservoir size in the bands 102 is preferably sized to adequately apply the drug/drug combination dosage at the desired location and in the desired amount.

In an alternate exemplary embodiment, the entire inner and outer surface of the stent 100 may be coated with various drug and drug combinations in therapeutic dosage amounts. A detailed description of exemplary coating techniques is described below.

Rapamycin or any of the drugs, agents or compounds described above may be incorporated into or affixed to the stent in a number of ways and utilizing any number of biocompatible materials. In the exemplary embodiment, the rapamycin is directly incorporated into a polymeric matrix and sprayed onto the outer surface of the stent. The rapamycin elutes from the polymeric matrix over time and enters the surrounding tissue. The rapamycin preferably remains on the stent for at least three days up to approximately six months and more preferably between seven and thirty days.

Any number of non-erodible polymers may be utilized in conjunction with rapamycin. In the exemplary embodiment, the polymeric matrix comprises two layers. The base layer comprises a solution of ethylene-co-vinylacetate and polybutylmethacrylate. The rapamycin is incorporated into this layer. The outer layer comprises only polybutylmethacrylate and acts as a diffusion barrier to prevent the rapamycin from eluting too quickly and entering the surrounding tissues. The thickness of the outer layer or top coat determines the rate at which the rapamycin elutes from the matrix. Essentially, the rapamycin elutes from the matrix by diffusion through the polymer molecules. Polymers tend to move, thereby allowing solids, liquids and gases to escape therefrom. The total thickness of the polymeric matrix is in the range from about 1 micron to about 20 microns or greater. In a preferred exemplary embodiment, the base layer, including the polymer and drug, has a thickness in the range from about 8 microns to about 12 microns and the outer layer has a thickness in the range from about 1 micron to about 2 microns.

The ethylene-co-vinylacetate, polybutylmethacrylate and rapamycin solution may be incorporated into or onto the stent in a number of ways. For example, the solution may be sprayed onto the stent or the stent may be dipped into the solution. In a preferred embodiment, the solution is sprayed onto the stent and then allowed to dry. In another exemplary embodiment, the solution may be electrically charged to one polarity and the stent electrically changed to the opposite polarity. In this manner, the solution and stent will be attracted to one another. In using this type of spraying process, waste may be reduced and more control over the thickness of the coat may be achieved.

Since rapamycin works by entering the surrounding tissue, it is preferably only affixed to the surface of the stent making contact with one tissue. Typically, only the outer surface of the stent makes contact with the tissue. Accord-

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ingly, in a preferred embodiment, only the outer surface of the stent is coated with rapamycin. For other drugs, agents or compounds, the entire stent may be coated.

It is important to note that different polymers may be utilized for different stents. For example, in the above-described embodiment, ethylene-co-vinylacetate and polybutylmethacrylate are utilized to form the polymeric matrix. This matrix works well with stainless steel stents. Other polymers may be utilized more effectively with stents formed from other materials, including materials that exhibit superelastic properties such as alloys of nickel and titanium.

Although shown and described is what is believed to be the most practical and preferred embodiments, it is apparent that departures from specific designs and methods described and shown will suggest themselves to those skilled in the art and may be used without departing from the spirit and scope of the invention. The present invention is not restricted to the particular constructions described and illustrated, but should be constructed to cohere with all modifications that may fall within the scope of the appended claims.

What is claimed is:

1. A drug delivery device comprising: an intraluminal stent; a biocompatible, nonerodible polymeric coating affixed to the intraluminal stent; and from about 64  $\mu$ g to about 197  $\mu$ g of rapamycin or a macrocyclic triene analog thereof that binds FKBP12 incorporated into the polymeric coating, wherein said device provides an in-stent late loss in diameter at 12 months following implantation in a human of less than about 0.5 mm, as measured by quantitative coronary angiography.

2. A drug delivery device according to claim 1 that provides an in-stent late loss in diameter at 12 months following implantation in a human of less than about 0.3 mm, as measured by quantitative coronary angiography.

3. A drug delivery device according to claim 1 or 2 that provides an in-stent diameter stenosis at 12 months following implantation in a human of less than about 22%, as measured by quantitative coronary angiography.

4. A drug delivery device according to claim 3 that provides an in-stent diameter stenosis at 12 months following implantation in a human of less than about 15%, as measured by quantitative coronary angiography.

5. A drug delivery device comprising: an intraluminal stent; a biocompatible, nonerodible polymeric coating affixed to the intraluminal stent; and from about 64  $\mu$ g to about 197  $\mu$ g of rapamycin or a macrocyclic triene analog thereof that binds FKBP12 incorporated into the polymeric coating, wherein said device provides a mean in-stent late loss in diameter in a human population at 12 months following implantation of less than about 0.5 mm, as measured by quantitative coronary angiography.

6. A drug delivery device according to claim 5 that provides a mean in-stent late loss in diameter in a human population at 12 months following implantation of less than about 0.3 mm, as measured by quantitative coronary angiography.

7. A drug delivery device according to claim 5 or 6 that provides a mean in-stent diameter stenosis in a human population at 12 months following implantation of less than about 22%, as measured by quantitative coronary angiography.

8. A drug delivery device according to claim 7 that provides a mean in-stent diameter stenosis in a human population at 12 months following implantation of less than about 15%, as measured by quantitative coronary angiography.

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9. A method of inhibiting neointimal proliferation in a human coronary artery resulting from percutaneous transluminal coronary angioplasty comprising implanting in the lumen of said coronary artery a drug delivery device comprising: an intraluminal stent; a biocompatible, nonerodible polymeric coating affixed to the intraluminal stent; and from about 64  $\mu$ g to about 197  $\mu$ g of rapamycin or a macrocyclic triene analog thereof that binds FKBP12 incorporated into the polymeric coating, wherein said method provides an in-stent late loss in diameter at 12 months following implantation of less than about 0.5 mm, as measured by quantitative coronary angiography.

10. A method according to claim 9 that provides an in-stent late loss in diameter at 12 months following implantation of less than about 0.3 mm, as measured by quantitative coronary angiography.

11. A method according to claim 9 or 10 that provides an in-stent diameter stenosis at 12 months following implantation of less than about 22%, as measured by quantitative coronary angiography.

12. A method according to claim 11 that provides an in-stent diameter stenosis at 12 months following implantation of less than about 15%, as measured by quantitative coronary angiography.

13. A method of inhibiting neointimal proliferation in a coronary artery resulting from percutaneous transluminal coronary angioplasty comprising implanting in the lumen of said coronary artery a drug delivery device comprising: an intraluminal stent; a biocompatible, nonerodible polymeric coating affixed to the intraluminal stent; and from about 64  $\mu$ g to about 197  $\mu$ g of rapamycin or a macrocyclic triene analog thereof that binds FKBP12 incorporated into the polymeric coating, wherein said method provides a mean in-stent late loss in diameter in a human population at 12 months following implantation of less than about 0.5 mm, as measured by quantitative coronary angiography.

14. A method according to claim 13 that provides a mean in-stent late loss in diameter in a human population at 12 months following implantation of less than about 0.3 mm, as measured by quantitative coronary angiography.

15. A method according to claim 13 or 14 that provides a mean in-stent diameter stenosis in a human population at 12 months following implantation of less than about 22%, as measured by quantitative coronary angiography.

16. A method according to claim 15 that provides a mean in-stent diameter stenosis in a human population at 12 months following implantation of less than about 15%, as measured by quantitative coronary angiography.

17. The drug delivery device according to any one of claims 1, 2, 4 or 5 wherein said rapamycin or macrocyclic triene analog thereof is incorporated into the polymeric coating at a dose of from about 64  $\mu$ g to about 125  $\mu$ g.

18. The drug delivery device according to any one of claims 1, 2, 4 or 5 that releases a portion of said dose of rapamycin or a macrocyclic triene analog thereof at about six weeks following intraluminal implantation.

19. The drug delivery device according to any one of claims 1, 2, 4 or 5 wherein said rapamycin or macrocyclic triene analog thereof is incorporated into the polymeric coating at a dose of from about 2  $\mu$ g to about 30  $\mu$ g per millimeter of stent length.

20. The drug delivery device according to claim 19 wherein said rapamycin or macrocyclic triene analog thereof is incorporated into the polymeric coating at a dose of from about 3  $\mu$ g to about 13  $\mu$ g per millimeter of stent length.

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21. The drug delivery device according to claim 19 that releases a portion of said dose of rapamycin or a macrocyclic triene analog thereof at about six weeks following intraluminal implantation.

22. The method according to any one of claims 9, 10, 13 or 14, wherein said rapamycin or macrocyclic triene analog thereof is incorporated into the polymeric coating at a dose of from about 64  $\mu\text{g}$  to about 125  $\mu\text{g}$ .

23. The method according to any one of claims 9, 10, 13 or 14, wherein said rapamycin or macrocyclic triene analog thereof is incorporated into the polymeric coating at a dose of from about 2  $\mu\text{g}$  to about 30  $\mu\text{g}$  per millimeter of stent length.

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24. The method according to any one of claims 9, 10, 13 or 14, wherein said rapamycin or macrocyclic triene analog thereof is incorporated into the polymeric coating at a dose of from about 3  $\mu\text{g}$  to about 13  $\mu\text{g}$  per millimeter of stent length.

25. The method according to any one of claims 9, 10, 13 or 14, wherein said drug delivery device releases a portion of said dose of rapamycin or a macrocyclic triene analog thereof at about six weeks following intraluminal implantation.

\* \* \* \* \*

# Multiple growth factors are released from mechanically injured vascular smooth muscle cells

STEPHEN T. CROWLEY, CARLA J. RAY, DILSHER NAWAZ,  
RICHARD A. MAJACK, AND LAWRENCE D. HORWITZ

*Division of Cardiology, Denver Veterans Affairs Medical Center, Denver 80220;  
and Division of Cardiology and Department of Pediatrics, University of Colorado  
School of Medicine, Denver, Colorado 80262.*

**Crowley, Stephen T., Carla J. Ray, Dilsher Nawaz, Richard A. Majack, and Lawrence D. Horwitz.** Multiple growth factors are released from mechanically injured vascular smooth muscle cells. *Am. J. Physiol.* 269 (*Heart Circ. Physiol.* 38): H1641–H1647, 1995.—Local release of mitogenic and chemotactic signals during angioplasty-induced vascular injury may initiate restenosis. We investigated whether mechanical injury to vascular smooth muscle cells (VSMC) results in the release of biologically active peptide growth factors. Monolayers of bovine SMC cultures were mechanically injured by cell scraping. Conditioned medium (CM) from control and injured SMC cultures was collected, and the mitogenic activity was measured by [<sup>3</sup>H]thymidine incorporation in recipient SMC cultures. Mitogenic activity from injured CM was detected within 15 min after injury. When the CM from injured cells was removed 15 min after injury and replaced with serum-free media, there was no detectable mitogenic activity in the replacement CM assessed 1–6 days postinjury. Suramin, a nonspecific peptide growth factor antagonist, significantly inhibited the mitogenic activity of injured CM. Basic fibroblast growth factor (bFGF), platelet-derived growth factor (PDGF A chain), and epidermal growth factor (EGF) were detected in CM from injured cells by immunoblot analysis. The mitogenic activity of injured CM was significantly inhibited with neutralizing antibodies to bFGF (34%), PDGF-AA (32%), PDGF-BB (25%), and EGF (25%). A neutralizing antibody to transforming growth factor (TGF)- $\beta$  had no effect. In conclusion, bFGF, PDGF, and EGF are immediately released from mechanically injured VSMC. VSMC likely contain preformed, biologically active growth factors that are efficiently released from the cell cytoplasm following mechanical injury. Conditioned medium from injured VSMC is highly mitogenic, and this activity is probably due to multiple growth factors interacting synergistically.

angioplasty; restenosis; proliferation

CATHETER-BASED TECHNIQUES used to treat obstructive vascular disease invariably cause mechanically induced vessel injury. Vascular smooth muscle cells (VSMC) activation and exuberant intimal proliferation with subsequent extracellular matrix deposition are triggered in response to vascular injury and are the primary causes of restenosis following angioplasty (26, 12). The cellular signals that initiate and sustain these responses are unknown.

Local release of peptide growth factors from injured or dead VSMC has been proposed to be an early mechanism for the generation of mitogenic and chemotactic signals following vascular injury (1, 28). The importance of this mechanism is supported by previous studies which demonstrate that the degree of intimal lesion formation is proportional to the degree of vascular injury (4, 30).

Thus the degree of vascular injury is an important determinant of VSMC proliferation. It has been proposed that basic fibroblast growth factor (bFGF), which lacks a signal peptide sequence necessary for cell secretion, and is abundant within the vessel wall before injury, is the primary mitogen released by mechanically injured VSMC (17). However, VSMC are known to synthesize several other peptide growth factors, including platelet-derived growth factor (PDGF) (33), epidermal growth factor (EGF and heparin-binding EGF) (16, 32), and transforming growth factor- $\beta$  (TGF- $\beta$ ) (21). To date, no study has clearly defined which growth factors are released from injured VSMC in sufficient quantities to stimulate growth. We hypothesized that mechanically injured SMC release multiple growth factors, which could interact synergistically at a local level to stimulate VSMC proliferation or migration early after vascular injury.

In this study, we demonstrated by immunoblot analysis and antibody neutralization studies that mechanically injured vascular VSMC immediately release the biologically active growth factors bFGF, PDGF, and EGF. Although these factors are released in small quantities, they probably interact synergistically to produce a significant mitogenic signal. Therefore, release of multiple growth factors due to mechanical injury may be an important early mitogenic stimulus for VSMC proliferation.

## METHODS

**Cell culture.** Medial explants were dissected from freshly harvested bovine aortic strips and plated in 100-mm petri dishes (29). Aortic SMC were grown from explants in minimal essential medium (MEM) containing 10% bovine calf serum (BCS) (HyClone, Logan, UT), nonessential amino acids, 100  $\mu$ g/ml penicillin, and 100  $\mu$ g/ml streptomycin (Sigma Chemical, St. Louis, MO). Explant-derived cells were initially passed after pretreatment with 0.05% trypsin-0.02% EDTA (Sigma) for 5 min at 37°C. Passage 3–6 cells were used for all growth studies. The authenticity of the aortic SMC cultures was verified by immunohistochemical staining using a monoclonal antibody specific for smooth muscle actin (CGA-7) (10). Cells were subcultured into 24-well culture plates in medium containing 10% serum for 24 h at an initial density of  $5 \times 10^4$  cells/well. The cells were then placed in medium containing 0.1% serum for 48 h to render them quiescent. Four replicate wells were used for each experimental condition.

**Cell injury assay.** Confluent cultures of quiescent VSMC grown in 24-well plates were injured by scraping the cell monolayer with a rubber policeman or cell scraper (Fisher). Each culture well was scraped in a systematic manner, in which two circumferential and three horizontal and vertical scrapes were made. By direct visualization ~80% of the cell

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H1642

GROWTH FACTOR RELEASE FROM INJURED SMC

monolayer surface area was injured and detached from the well surface after injury. This degree of mechanical injury resulted in 25% cell death determined 24 h after injury by trypan blue staining. Disrupted, but viable, cells reattached to the culture well after 24 h. Cell injury was performed under serum-free conditions, and the conditioned medium (CM) was collected at various time points after injury. Cell debris was removed by centrifugation (2,000 rpm  $\times$  5 min at 20°C).

**Growth activity assay.** Equal volumes (1 ml) of injured and noninjured CM were added to separate quiescent recipient VSMC cultures (24-well plates). Other recipient cultures received an equal volume of MEM with 10% BCS, which served as maximally stimulated control cultures. Each well was pulsed with 0.5  $\mu$ Ci [ $^3$ H]thymidine at 18 h of incubation. At 24 h of incubation, the cells were rinsed twice with 1 ml of phosphate-buffered saline (PBS) and then fixed with 0.2 M perchloric acid. Wells were aspirated and rinsed again with PBS, and the acid-precipitated cellular material was solubilized with 0.3 ml 0.01 N sodium hydroxide/1.0% sodium dodecyl sulfate (SDS). The contents of each well were added to 4 ml of Ecoscint (National Diagnostics, Atlanta, GA), and radioactivity was measured with a Beckman (LS 7500; Irvine, CA) beta-scintillation counter. Incorporation of [ $^3$ H]thymidine into SMC DNA was expressed as counts per minute (cpm) per well.

**Preparation of conditioned media for immunoblot analysis.** Quiescent VSMC grown to confluence in 8–10 T 75 cm<sup>2</sup> flasks were mechanically injured with a plastic cell scraper in 5 ml of serum-free MEM containing 0.1% BSA and 2.5  $\mu$ g/ml of the following protease inhibitors: leupeptin, aprotinin, chymostatin, pepstatin A, and antipain. The cell monolayer was completely disrupted to injure as many cells as possible (> 95% of the surface area). Medium was collected 15 min after injury, then the CM was pooled and centrifuged (1,400 g) for 10 min at 4°C to remove cellular debris. The CM was concentrated using a Centrprep 3 or 10 (Amicon, Beverly, MA) and centrifuged (3,000 g) for 4–6 h at 4°C. CM was also obtained from uninjured SMC cultures and prepared in an identical manner.

**Immunoprecipitation assay.** Concentrated CM samples were incubated overnight with mouse anti-bovine bFGF II monoclonal antibody (7.0  $\mu$ g/ml), followed by a 2-h incubation period with protein G-agarose. Extraneous proteins were removed with three cycles of salt/detergent washes, and the agarose beads were then incubated with SDS-polyacrylamide gel electrophoresis (PAGE) sample buffer with  $\beta$ -mercaptoethanol for 5 min at 95°C.

**Heparin-sepharose purification.** Concentrated CM (5–6 ml) was incubated overnight with 0.5 ml packed heparin-Sepharose (Pharmacia). The samples were prepared in 10-ml columns and sequentially eluted with 5 ml of 0.1 M sodium acetate/0.1 M sodium chloride/10 mM 3-[(3-cholamidopropyl)-dimethylammonio]-1-propanesulfonate (CHAPS) (pH 5.0), followed by 0.1 M sodium acetate/0.1 M sodium chloride/0.16 mM CHAPS (pH 5.0), then 0.5 M tris(hydroxymethyl)aminomethane (Tris) pH 7.0/0.1 M sodium chloride, and finally with 2 ml of 0.05 M Tris (pH 7.0)/2.0 M sodium chloride. The product was concentrated with a Centricon 3 (EGF) or Centricon 10 (PDGF) to 0.1 ml and desalted with 10 mM acetic acid.

**Immunoblot analysis.** Concentrated and immunoprecipitated (bFGF) and heparin-sepharose purified (PDGF, EGF) CM were subjected to 15% (bFGF), 12% (PDGF), or 4–20% continuous (EGF) SDS-PAGE, and then transferred to a nitrocellulose membrane. The membrane was blocked with 5% nonfat dry milk for 1 h and then incubated with the primary antibody overnight at 4°C. bFGF was run on a reducing gel, whereas both PDGF and EGF were run under nonreducing

conditions. The following primary antibodies were used: mouse anti-bovine bFGF, type II, monoclonal (Upstate Biotechnology, Lake Placid, NY); rabbit anti-human recombinant PDGF-AA and -BB polyclonal (Genzyme, Cambridge, MA); and goat anti-human recombinant EGF, polyclonal (R and D Systems, Minneapolis, MN). The blot was then washed and incubated with the horseradish peroxidase (HRP)-conjugated polyclonal secondary antibody for 1 h [bFGF: sheep anti-mouse immunoglobulin (Ig)-HRP at 1/10,000 dilution (Amersham); PDGF: donkey anti-rabbit Ig-HRP at 1/10,000 dilution (Amersham); EGF: rabbit anti-goat IgG-HRP at 1/4,000 dilution (Sigma)], and proteins were detected by ECL luminescence (Amersham).

**Antibody neutralization assay.** CM from injured cells was preincubated with specific neutralizing antigrowth factor antibody or mouse IgG for 2 h at 37°C, after which the treated CM was added to recipient VSMC cultures and cell proliferation determined after 24 h of incubation. The neutralizing capability and specificity of commercially obtained antibodies were verified in control experiments against each growth factor. bFGF standard with and without specific or nonspecific antibody was preincubated, but unlike PDGF or EGF, was then added directly to the recipient VSMC cultures without changing the medium. Presence of the quiescent media was necessary for the recipient cells to respond to exogenous bFGF. The anti-PDGF and anti-EGF antibodies used for immunoblot analysis also demonstrated neutralizing capability and were employed in these studies. In addition, a rabbit anti-bovine bFGF polyclonal antibody (Sigma) was used to neutralize bFGF.

**Statistical analysis.** Data points represent the mean value of replicate samples  $\pm$  SE. One-way analysis of variance was used for multiple group comparisons, and a *P* value of < 0.05 using the Student-Newman-Keuls test was considered to be significant.

## RESULTS

**Mitogenic response of SMC to mechanical injury.** At a series of time points following mechanical injury, CM was removed from cultures, and its mitogenic activity was assayed in quiescent recipient VSMC cultures. Within 5 min after mechanical injury marked mitogenic activity was observed in medium from injured cultures (Fig. 1). Injured VSMC cultures, in which the CM was removed 15 min after injury and replaced with 0.1% BCS medium, did not release significant amounts of mitogenic activity into the replacement medium during a period of 2–6 days postinjury (Fig. 2). These results indicate that SMC contain preformed, biologically active mitogens, which are released immediately following mechanical injury. Because we did not detect significant mitogenic activity in replacement CM added 15 min postinjury, it appears that mechanical injury did not induce VSMC to synthesize and secrete growth factors during the postinjury “recovery” period.

**Characterization of growth activity from injured conditioned media.** To initially determine whether the mitogenic activity from injured CM was due to the presence of peptide growth factors, recipient VSMC were treated with CM with or without suramin, a nonspecific peptide growth factor antagonist (24). In a concentration-responsive manner, suramin (10–500  $\mu$ g/ml) significantly inhibited the mitogenic activity of injured CM (Fig. 3). At these concentrations, suramin

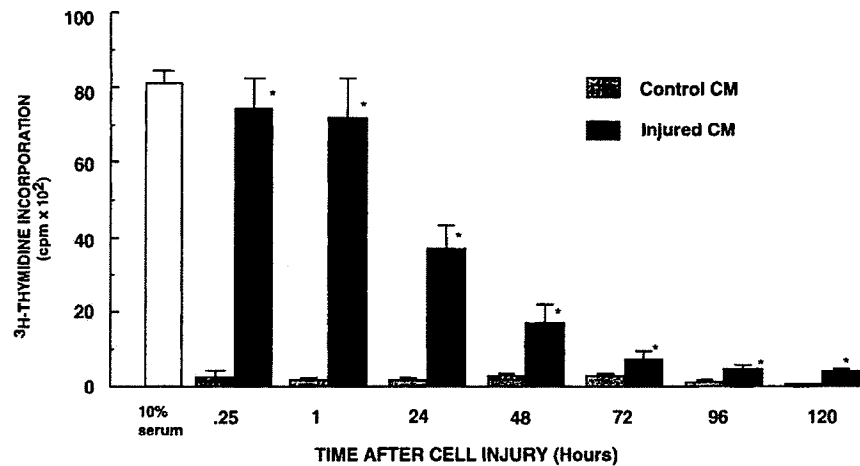


Fig. 1. Bar graph demonstrating the degree of mitogenic activity of 10% serum control and that recovered from injured and noninjured vascular smooth muscle cells (VSMC) cultures at various time points after injury. Medium was not changed after cell injury and allowed to condition for the time indicated. After centrifugation to remove cell debris, equal volumes of conditioned medium (CM) were added directly to recipient VSMC cultures. Mitogenic activity was assessed after 24 h of incubation by [<sup>3</sup>H]thymidine incorporation. \*Significant mitogenic effect compared with noninjured control,  $n = 4$ .

was not toxic to quiescent uninjured VSMC by trypan blue staining and did not induce a significant change in basal [<sup>3</sup>H]thymidine incorporation or cell number.

**Identification of specific growth factors from mechanically injured SMC.** By immunoblot analysis immunoreactive proteins corresponding to bFGF, PDGF(AA/AB), and EGF were identified in injured CM (Figs. 4, 5, and 6). Anti-bFGF antibody recognized a 16- to 18-kDa protein corresponding to bFGF, and a second band at 32–34 kDa was also identified which may represent bFGF dimers (Fig. 4). No bands corresponding to bFGF were seen in noninjured CM or media alone. There was no cross-reactivity of the anti-bFGF antibody with samples spiked with PDGF or EGF (data not shown).

A 28-kDa protein consistent with PDGF was identified in injured CM with an anti-PDGF AA/AB antibody, which recognizes an A-chain epitope (Fig. 5). We could not detect PDGF by immunoblot with anti-PDGF BB/AB antibody (B-chain recognition) (data not shown). Therefore, we detected only PDGF-A chain from injured VSMC. Cross-reactivity of the PDGF antibodies to either bFGF or EGF by immunoblot was not observed.

A 6- to 8-kDa protein corresponding to EGF was identified in injured CM using a gradient gel (Fig. 6).

This anti-EGF antibody also recognized a weak band at 19–23 kDa, which may correspond to the heparin-binding EGF (Hb-EGF) recently described as a 19- to 23-kDa protein produced by SMC and other cells (13). However, according to the manufacturer, this anti-EGF antibody does not react with Hb-EGF. EGF was not detected in uninjured control CM and cross-reactivity of the anti-EGF antibody with PDGF or bFGF was not observed.

**Antibody neutralization of growth-promoting activity in conditioned media of injured SMC.** Mitogenic activity from injured CM was substantially neutralized by antibodies to bFGF (34%), PDGF AA/AB (32%), PDGF BB/AB (25%), and by EGF (25%). Neutralizing antibodies to TGF- $\beta$  inhibited mitogenic activity by only 9% (Fig. 7). The combination of anti-bFGF and PDGF-AA antibodies resulted in a 45% inhibition of mitogenic activity. Nonspecific immunoglobulin IgG did not inhibit VSMC proliferation in response to bFGF, PDGF, or EGF. In our cell culture system anti-PDGF A chain antibody (2–15  $\mu$ g/ml) neutralized the growth effect of PDGF-AA (10 ng/ml) by 100%, anti-PDGF B chain (7–15  $\mu$ g/ml) neutralized 100% of PDGF-BB stimulation (10 ng/ml), and both antibodies neutralized

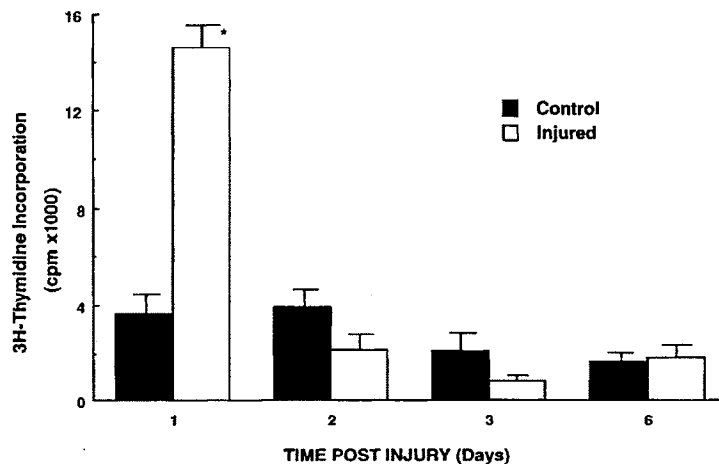
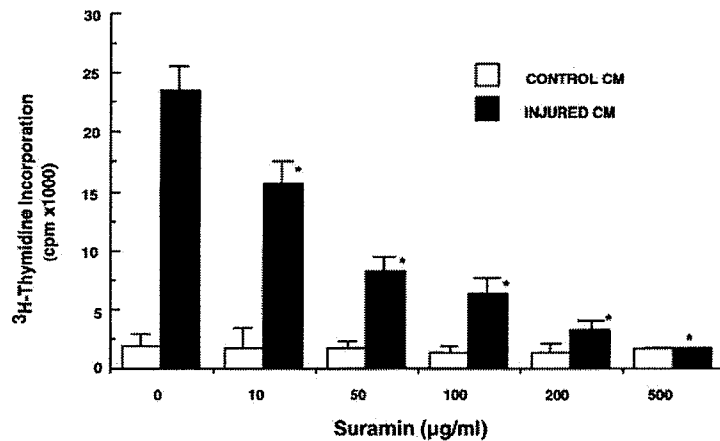


Fig. 2. Bar graph illustrating late release (1–6 days postinjury) of mitogenic activity from injured VSMC. After mechanical injury cultures were allowed to condition for 24 h, after which CM from injured and control cultures was removed and replaced by serum-free medium. At the time points indicated after this postinjury medium change, mitogenic activity of these injured cultures were assessed by [<sup>3</sup>H]thymidine incorporation. \*Significant mitogenic effect compared with control,  $n = 4$ .

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## GROWTH FACTOR RELEASE FROM INJURED SMC

Fig. 3. Bar graph demonstrating dose-response inhibitory effect of suramin on mitogenic activity recovered from injured VSMC cultures. CM, which was recovered from injured and noninjured cultures 1 h after injury, was harvested and applied to recipient VSMC cultures in presence or absence of suramin (0–500  $\mu\text{g}/\text{ml}$ ). Mitogenic activity of recipient VSMC cultures was assessed at 24 h. \*Significant inhibitory effect of suramin compared with untreated control,  $n = 4$ .



PDGF-AB stimulation by 50–80% at these concentrations. The anti-EGF antibody (10  $\mu\text{g}/\text{ml}$ ) neutralized EGF (5 ng/ml)-stimulated VSMC by 100%. The anti-bFGF antibody (100–150  $\mu\text{g}/\text{ml}$ ) neutralized 50–60% of bFGF mitogenic activity. At higher concentrations a nonspecific stimulatory effect was observed with this antibody (data not shown). According to manufacturer's information ~11% cross-reactivity is seen with the anti-PDGF antibody to PDGF A and B chains. This degree of cross-reactivity was confirmed in our culture system. Both our bFGF- and EGF-neutralizing antibodies did cross-react with PDGF (~20% of the PDGF proliferative response was reduced with these antibodies; data not shown). No significant cross-reactivity with EGF was seen with either the bFGF- or PDGF-neutralizing antibodies.

## DISCUSSION

The main objectives in this study were to determine whether and when specific biologically active peptide growth factors are released from mechanically injured VSMC. We used cell scraping to induce mechanical injury and identified, by immunoblot analysis and antibody neutralization studies, the presence of biologically active bFGF, PDGF, and EGF, which were released into the medium after injury. The model of cell scraping used in this report has been previously employed to induce mechanical injury in endothelial cells (23, 25) and has been shown to mimic plasma membrane disruptions sustained by cells in vivo (22). Although this technique has been used to induce injury in VSMC (15), there has been no information associating mechanical injury with specific growth factor release from VSMC.

Mechanical injury induced by cell scraping resulted in immediate recovery of mitogenic activity from CM. The mitogenic activity recovered from individual cultures was comparable in degree to the growth induced by the

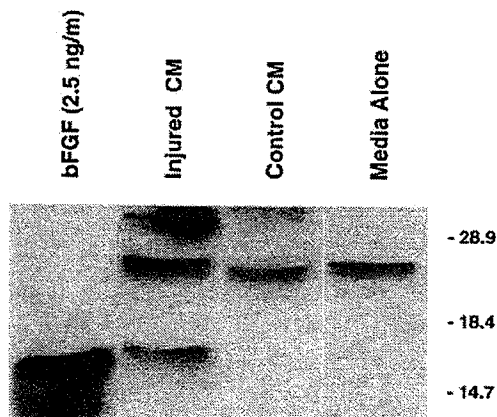


Fig. 4. Immunoblot of CM obtained from VSMC cultures probed with mouse anti-bovine basic fibroblast growth factor (bFGF) monoclonal antibody (1  $\mu\text{g}/\text{ml}$ ). Fifteen minutes after cell injury, CM was collected from cultures, pooled, and centrifuged to remove cell debris. CM (lanes 2–4) was concentrated (see METHODS) and subjected to overnight immunoprecipitation with mouse anti-bovine FGF monoclonal antibody (7.0  $\mu\text{g}/\text{ml}$ ). Lane 1: human recombinant peroxidase-bFGF standard (2.5 ng); lane 2: injured CM; lane 3: uninjured control CM; lane 4: uninjured CM without antibody. bFGF standard (lane 1) was diluted in minimal essential medium (MEM) and loaded directly on gel. Band at 24 kDa was identified as immunoglobulin light chain of immunoprecipitated antibody. Molecular sizes (kDa) are as indicated.

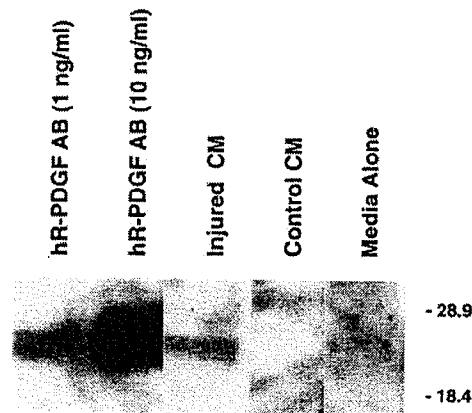


Fig. 5. Immunoblot of CM probed with rabbit anti-human recombinant (hR) PDGF(AA/AB) polyclonal antibody (10  $\mu\text{g}/\text{ml}$ ). Concentrated CM was heparin-Sepharose purified (see METHODS) and subjected to 12% sodium dodecyl sulfate-polyacrylamide gel electrophoresis (SDS-PAGE). Lane 1: hR-PDGF-AB (1.0 ng/ml); lane 2: hR-PDGF-AB (10 ng/ml); lane 3: injured CM; lane 4: control uninjured CM; lane 5: medium alone (MEM).



## GROWTH FACTOR RELEASE FROM INJURED SMC

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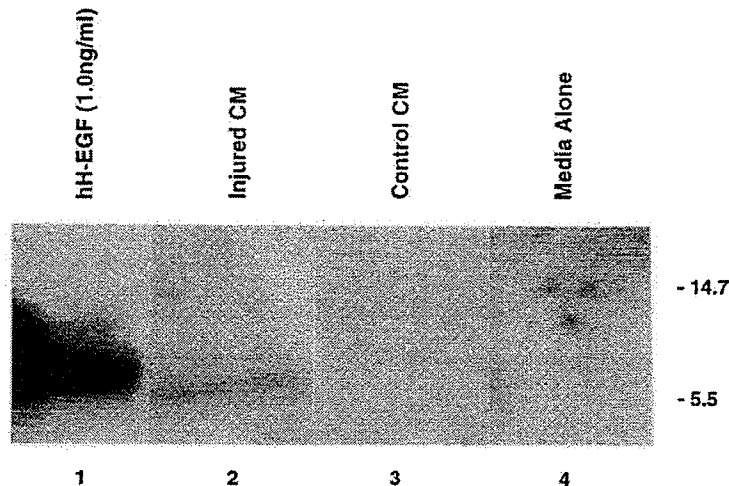


Fig. 6. Immunoblot of CM probed with goat anti-human recombinant(hh)-EGF polyclonal antibody (5  $\mu$ g/ml). Concentrated CM was heparin-Sepharose purified and subjected to 4–20% gradient SDS-PAGE. Lane 1: hh-EGF (1.0 ng/ml; lane 2: injured CM; lane 3: control uninjured CM; lane 4: medium alone (MEM).

addition of 10% serum. This activity peaked within 1 h and remained detectable for days after injury. However, if the medium was removed within 15 min after injury and replaced with serum-free medium, very little additional mitogenic activity was found in media collected over the next 6 days postinjury. This suggests that VSMC contain preformed biologically active growth factors, which are quickly released into their local extracellular environment upon mechanical injury.

The rapid recovery of mitogenic activity from injured cultures of VSMC favors a cytosolic, rather than a vesicular or nuclear, location of these growth factors. Cytosolic location of bFGF in endothelial cells has previously been reported (8), and the identification of a 16- to 18-kDa bFGF band in this study is consistent with cytosolic bFGF found in other cell types (33). Matrix-bound growth factor, especially bFGF, could potentially be an alternative source of mitogenic activity following mechanical injury. However, in our model VSMC were

injured after 48 h in culture, when matrix deposition of bFGF is minimal compared with the amount of bFGF detectable intracellularly (31). Furthermore, Linder et al. (17) demonstrated predominantly cytoplasmic bFGF with some nuclear localization of bFGF within VSMC of uninjured rat carotid arteries by immunocytochemical staining. Although it is probable that injury-induced growth factor release did occur from matrix sites, it is more likely that much of the release occurred from a cytosolic source given the abundant presence of growth factor within cultured VSMC (31).

By immunoblot analysis we detected PDGF-A chain and not PDGF-B chain in CM from injured VSMC. PDGF-A chain is the predominant PDGF isoform produced by VSMC in vivo (20), but all isoforms have mitogenic and chemotactic effects on VSMC. We did observe a significant reduction in the mitogenic activity of injured CM with neutralizing anti-PDGF BB/AB antibody. Therefore, BB isoform, which may have been

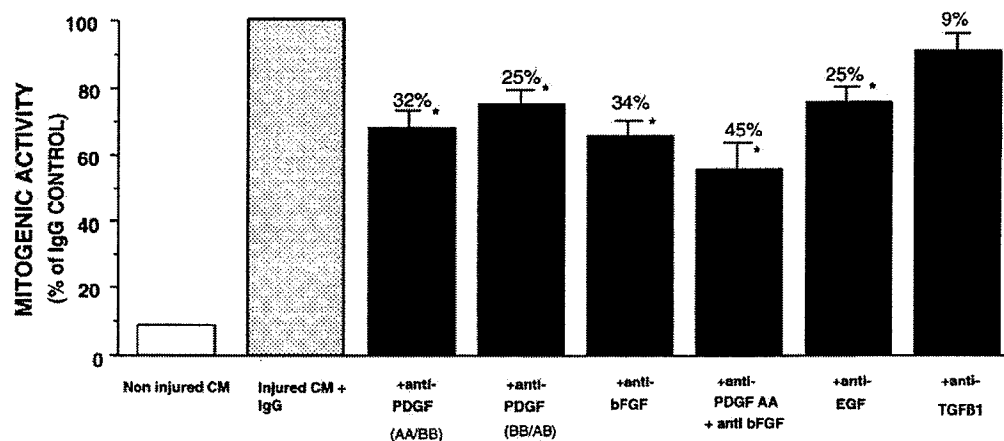


Fig. 7. Bar graph showing anti-growth factor antibody neutralization of injured CM. Degree of mitogenic inhibition is expressed as a percentage of immunoglobulin (Ig) G-treated injured CM control. CM was preincubated with specific neutralizing antibody: anti-bFGF (150  $\mu$ g/ml), anti-PDGF A or B chain (15  $\mu$ g/ml), anti-EGF (10  $\mu$ g/ml), or mouse IgG for 2 h at 37°C and then added to recipient VSMC cultures. \*Significant neutralizing effect compared with CM control treated with nonspecific IgG. Mitogenic activity was assessed at 24 h,  $n = 3$ .

present at a concentration below the threshold which we could detect by immunoblot analysis, could be contributing to the mitogenic activity of injured CM. However, since the anti-PDGF neutralizing antibodies used in our study displayed some cross-reactivity between PDGF-A and -B chains and with bFGF, we cannot confirm the presence of PDGF-BB isoform in injured CM. Likewise, it was not possible to accurately determine the relative contribution of each growth factor to the total mitogenic activity released by injured VSMC.

Because VSMC can both produce and respond to bFGF, PDGF, and EGF, these factors may work in concert to mediate initial responses to injury. It is well known that peptide growth factors interact synergistically to markedly enhance cell proliferation (7, 14). In addition, bFGF with its potential ability to regulate matrix proteins and plasminogen activators (2), may help facilitate the promigratory effect of PDGF and EGF. PDGF, in the setting of tissue injury, could act as a multifunctional protein, since it can increase the release of collagenase by fibroblasts (3) and induce chemoattracted macrophages and fibroblasts to synthesize TGF- $\beta$  (27). PDGF, EGF, and bFGF all have been strongly implicated in wound repair responses in nonvascular tissues (5, 11, 19) and have been shown to accelerate wound healing in other models (6). A specific antibody to PDGF has been demonstrated to inhibit VSMC replication after arterial injury (9), and an anti-bFGF antibody treatment has been shown to partially limit neointimal formation in a rat model (18). However, further investigation is needed to define the functional role these factors play in mediating vascular responses to injury.

Results from our study indicate that upon injury, VSMC release multiple growth factors, which include bFGF, PDGF, and EGF. Therefore, attempting to inhibit only one such factor is unlikely to significantly attenuate subsequent intimal lesion formation. These growth factors are each released in small quantities and probably interact synergistically to produce a strong mitogenic signal. Although we cannot exclude a role for other growth factors, local release of bFGF, PDGF, and EGF by injured VSMC following mechanical injury may provide an important early mitogenic stimulus after vascular injury.

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Address for reprint requests: S. T. Crowley, 1601 East 19th Ave., Suite 5100, Denver, CO 80218.

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\*-prò-n [NL, fr. Gk. lit., (the) later earlier, (the) latter first] (1565): a figure of speech consisting of the reversal of a natural or rational order (as in "then came the thunder and the lightning")

**hyster-o-to-my** \his-tə-ˈrā-to-mē, n, pl **-mies** [NL *hysterotomia*, fr. *hyster* + *-tomia* (-tomy)] (1801): surgical incision of the uterus; esp.

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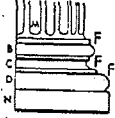
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## References

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base of a column; *B* upper torus; *C* scotia; *D* lower torus; *F*, *F*, *F*, fillets; *M* shaft; *N* plinth



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PHILIP BABCOCK GOVE, Ph.D.  
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